

Ageing **well**

A person-centred approach to later-life care



Lancashire and
South Cumbria
Integrated Care Board

Frailty Training



Jan- Feb 2024

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Why is frailty Important?

- Frailty is a distinct clinical state which there is decline in multiple physiological systems, Increased vulnerability to minor external stressors. Frailty varies in its severity and individuals should not be labelled as being frail or not frail but simply that they have frailty. (BGS, 2018)

Frailty is a major cause of hospital admissions in the UK with 4000 admissions to Accident and Emergency per-day (NHS Rightcare, 2019).

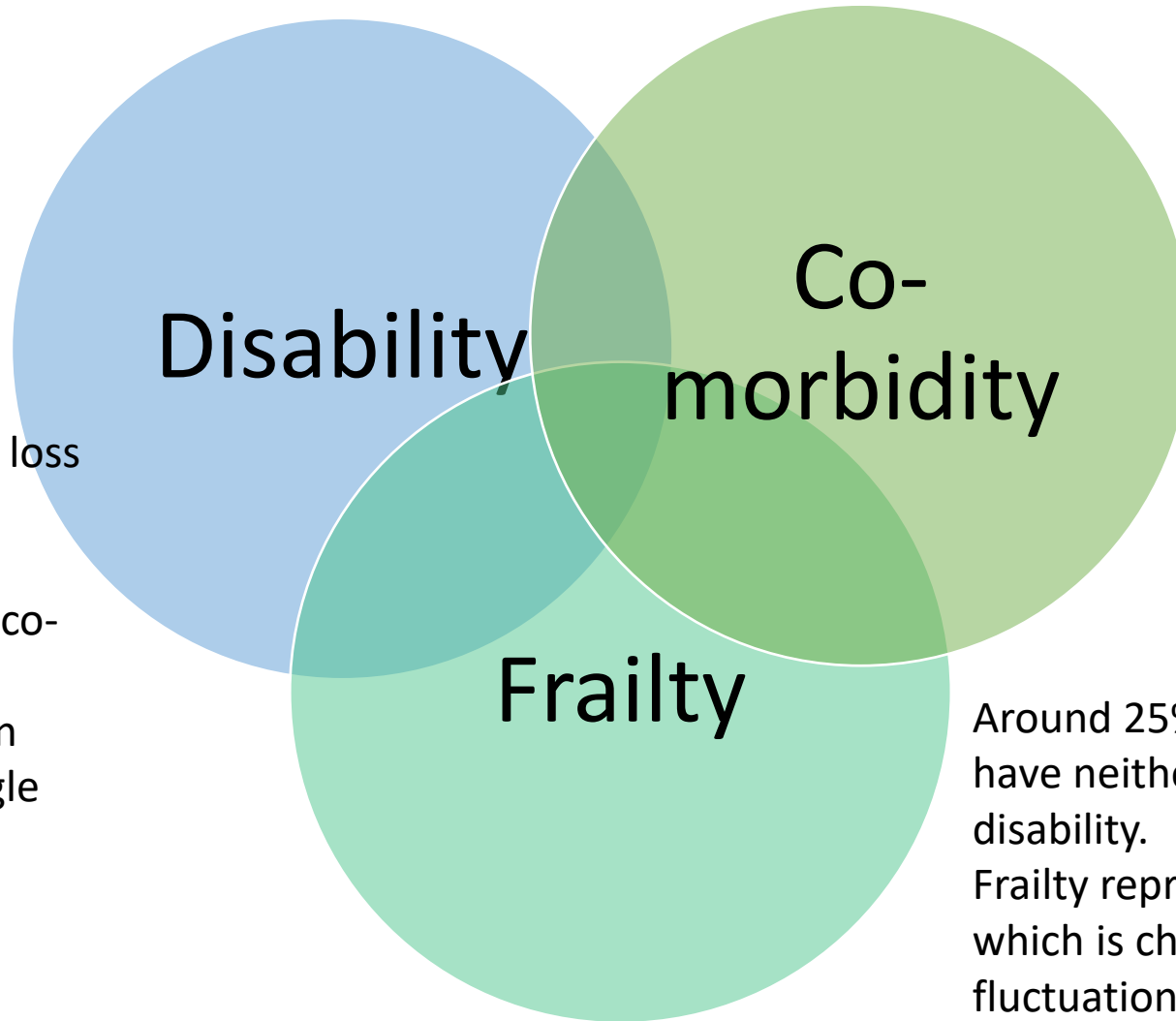
50% of people over the age of 65 are living with some degree of frailty and ageing well is a priority for NHS England (Frailty Framework, 2018, Joining The Dots, 2023).

It is estimated that 1 in 5 are over 65 in Lancashire and South Cumbria (Midlands and Lancashire commissioning Support Unit 2023)

Frailty is a major cause of mortality and morbidity worldwide (Solakoglu et al, 2023)



Prevalence and overlaps of co-morbidity, disability and frailty among community dwelling men and women 65 years +



Co-morbidity is the presence of 2 or more long term conditions (co-morbidity) Whilst most people who have frailty have co-morbidity, the majority of those with multimorbidity do not fit the criteria for frailty

Disability is a physical or mental impairment that has substantial negative effects on ability to undertake normal activities
It is a static and stable functional loss
Around 50% of disability in older adults develops chronically and progressively in association with co-morbidity and frailty
The remaining 50% of disability in older adults develops after a single event such as stroke

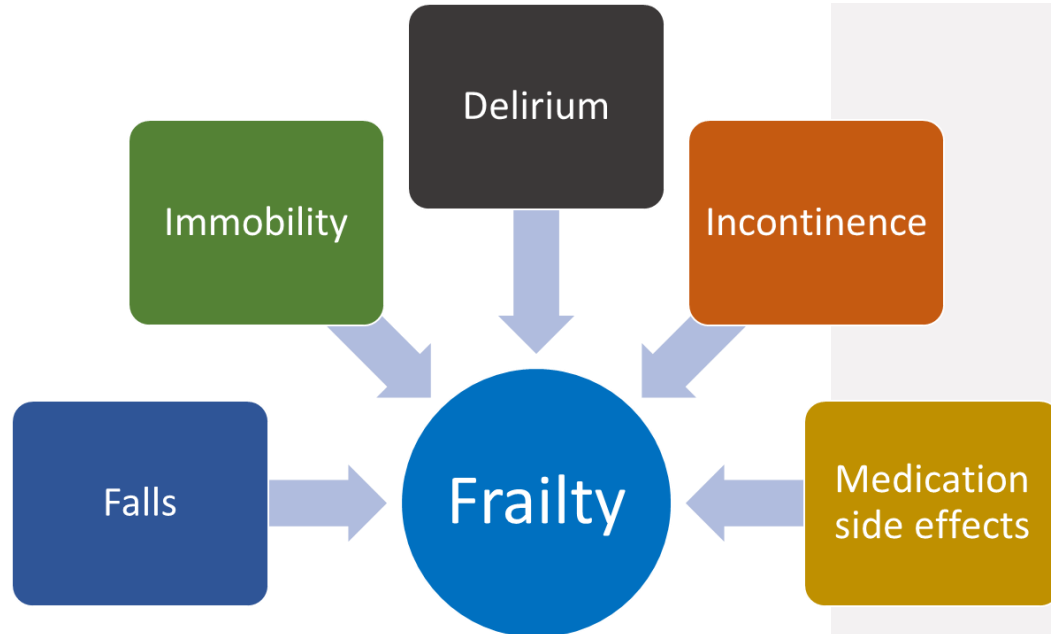
Around 25% of older people with Frailty have neither multiple co-morbidity nor disability.
Frailty represents a dynamic state which is characterised by fluctuations in function
It can be thought of as 'vulnerable'



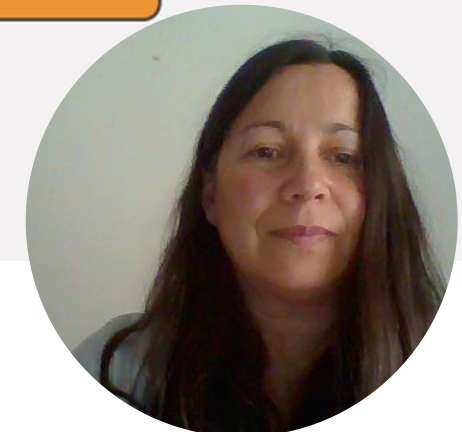
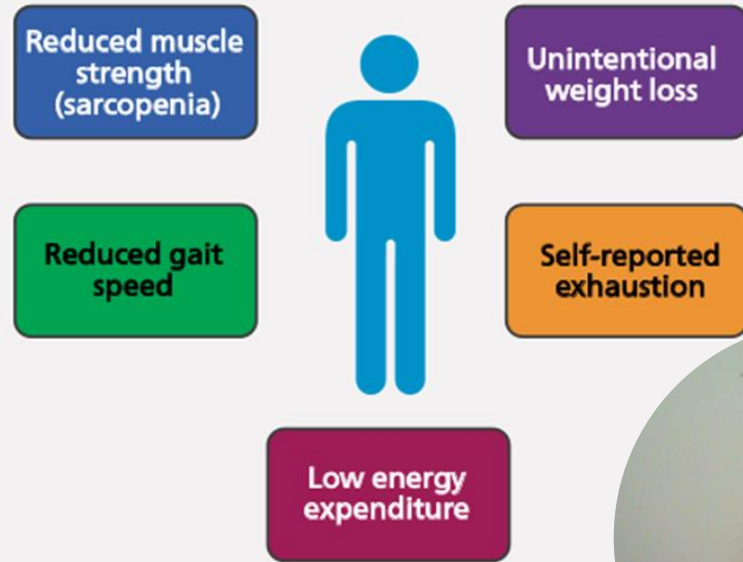
What exactly is Frailty and how can it affect people?

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Frailty phenotype model








How do I Identify Frailty?




- The Clinical frailty scale is validated for use in all 65+ individuals. It can be completed quickly.
- Document on EMIS – use the code: 763 264 000 (GP practice) or start to type ‘Rock’ and the Rockwood CFS will come up or in the template being used
- It can be used by all healthcare professionals
- You need to assess normal functional level therefore, if someone is in hospital or acutely unwell assess their status from at least 2 weeks ago
- • You may need to check normal function with relatives or other healthcare professions – don’t just guess from the pictures on the CFS

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CLINICAL FRAILTY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILTY	Previously “vulnerable,” this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up” and/or being tired during the day.
	5	LIVING WITH MILD FRAILTY	People who often have more evident slowing, and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

	6	LIVING WITH MODERATE FRAILTY	People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILTY	Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	8	LIVING WITH VERY SEVERE FRAILTY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

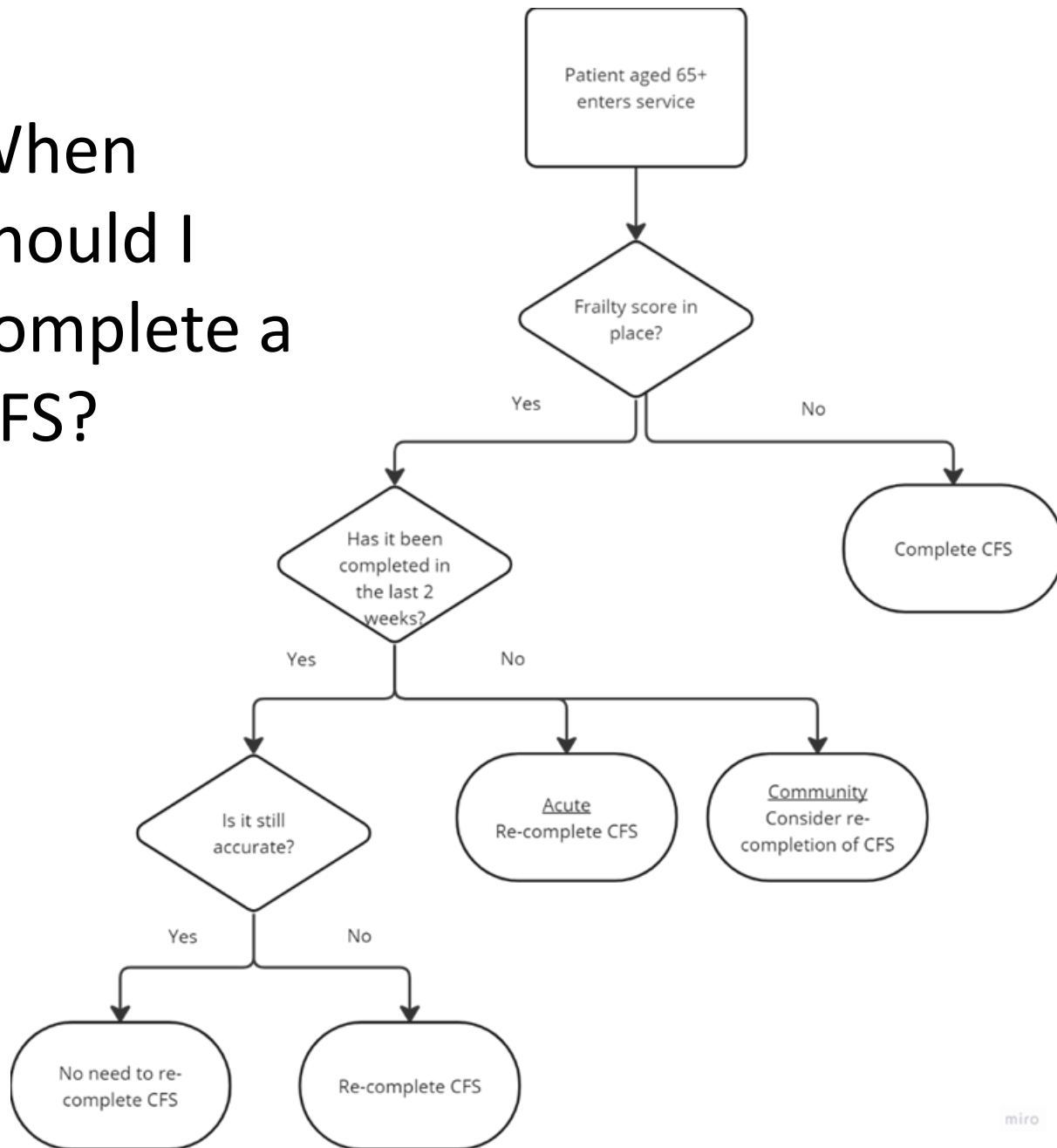
The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember the event. They can do some simple tasks. In severe dementia, people are unable to perform any tasks.

 DALHOUSIE UNIVERSITY



When should I complete a CFS?



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- This flow diagram is on the Good practice guide
- It can help you identify when to complete and when to revisit the CFS



After Frailty has been identified- What do I do next?

Frailty – Clinical Support Tool East Lancs

efi	Clinical Frailty Scale (CFS) Score	Clinical Prompts / discussions	Possible Personalised Care Planning Approach
0.12 or less	3 – Managing well 	<ul style="list-style-type: none"> <input type="checkbox"/> Eye check <input type="checkbox"/> Hearing check <input type="checkbox"/> Annual medication review <input type="checkbox"/> Annual Health check- LTC/>75 completed in the last 12 months <input type="checkbox"/> Healthy lifestyle advice <input type="checkbox"/> Exercise- local gym, social prescribers <input type="checkbox"/> Employment advice for those still working <input type="checkbox"/> Nutrition <input type="checkbox"/> Social circumstances <input type="checkbox"/> Advice on how to avoid disease trajectory 	<ul style="list-style-type: none"> • Local activity groups to socialise – specialised groups e.g., Veterans in Community (VIC) • CVS newsletter/CVS - social prescribers / community website • Consider smoking cessation, drug, and alcohol support services • Local Gym- exercise classes - LCC / Age UK / CVS • Employment support, pensions advice • Consider referral to Fire service for environmental checks / smoke alarms • Consider MSK physiotherapy referral if required
0.13-0.24	4 –Living with very mild frailty 	<ul style="list-style-type: none"> <input type="checkbox"/> Eye check <input type="checkbox"/> Hearing check <input type="checkbox"/> Annual medication review <input type="checkbox"/> Annual Health check- LTC/>75 completed in the last 12 months <input type="checkbox"/> Cognition <input type="checkbox"/> Mood <input type="checkbox"/> Continence <input type="checkbox"/> Nutrition <input type="checkbox"/> Social circumstances / isolation <input type="checkbox"/> Functional Independence <input type="checkbox"/> Social support 	<ul style="list-style-type: none"> • Local activity groups to socialise – specialised groups e.g. Veterans in Community (VIC) • CVS newsletter/CVS - social prescribers / community website • Local exercise & balance classes - LCC / Age UK / CVS • Strength & balance class via Interim • Services to support at home- Adapted services / equipment) / Homecare • Consider referral to Continence • Consider MSK physio referral • Consider referral to Fire service for environmental checks / smoke alarms

If a CFS score of 6 or greater is identified it is recommended that they have a Comprehensive Geriatric Assessment

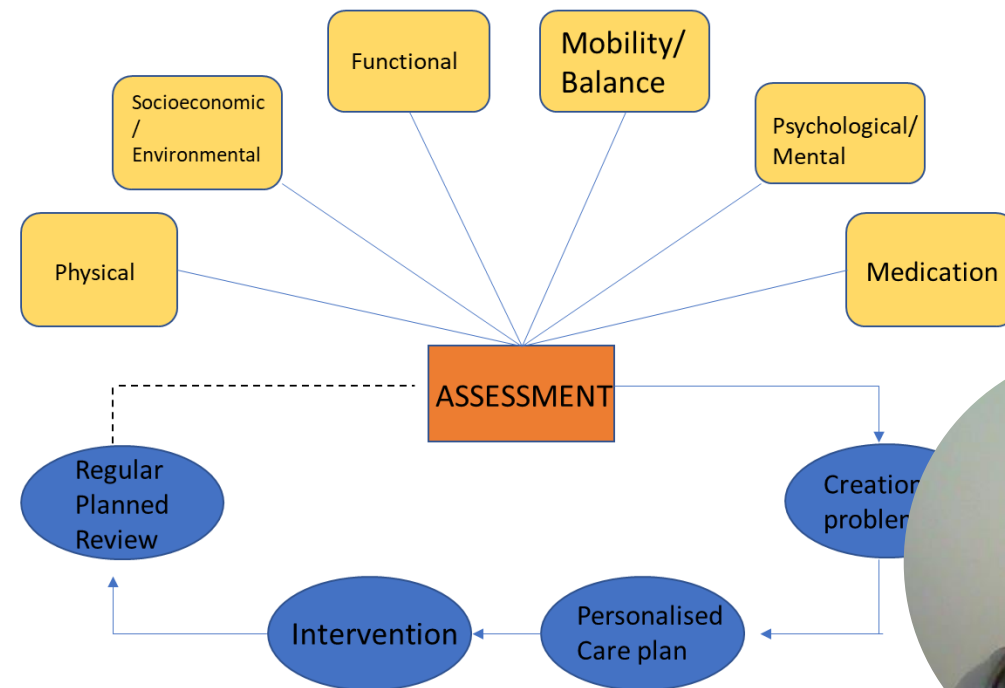
Please see the Good Practice Guide and Frailty Clinical Support tools to help guide your personalised care approach



What is a comprehensive Geriatric Assessment?

- If a CFS score of 6 or more it is recommended that they have a **Comprehensive Geriatric Assessment**
- **Gold standard care is Comprehensive Geriatric Assessment (CGA) and personalised care and support plans**
- **Consider onward referral to local specialist teams e.g. community rehab and Integrated Neighbourhood Teams**

CGA- Widely recommended as the gold standard for assessment and management of frailty



Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.



Identification: All over 65s in primary care

Electronic Frailty Index

Identification of any of the frailty syndromes (left), complete the CFS

Clinical Frailty Scale (CFS)

Personas and Clinical Frailty Scale



<p>CFS 1 Very fit</p> <p>Andy (in the Blue Vest) is 70 years young. He took up marathon running when he retired at the age of 60. He has planned well for his retirement and is living life to the full. Andy does not think age is a limitation and doesn't believe frailty is inevitable!</p>	<p>CFS 2 Fit</p> <p>Sarah is 68. Enjoys Pilates once per week. She's pretty fit other than the odd niggle. She walks with her friends during the summer months but does much less in the winter. She would like to move to a warmer climate but has family close by who need her, so she keeps dreaming!</p>	<p>CFS 3 Managing well Some reversible features</p> <p>Masoud is 70. He has COPD which is fairly well controlled. He is sometimes anxious, especially since covid and is less sociable. He gets out with his son monthly to do a longer walk but is not regularly active beyond routine walking.</p>	<p>CFS 4 Living with very mild frailty</p> <p>Khaleda is 68. She has arthritis, diabetes and high blood pressure. She is on multiple medications and chooses to take supplements in addition. She doesn't need any help with her activities of daily living but is starting to feel 'slowed up' and some days her symptoms limit her activity, particularly when the weather is bad and has a neighbour who helps occasionally in the snow and ice.</p>	<p>CFS 5 Living with mild frailty</p> <p>Mohammed is 80. He's been fit most of his life. He has Parkinson's disease and poor vision and uses frame and help of one person to mobilise. He goes to the mosque every Friday and for special occasions. In the summer he likes to sit outside and shake everyone's hands on the way in as he used to. He is an important person in his family and his wider community. People still go to him for advice.</p>	<p>CFS 6 Living with moderate frailty</p> <p>Maureen is 75. She has multiple health issues. She has had two new hips and has an artificial heart valve. Since her last hip replacement, she has carers 3x per day to help her with washing, dressing and meal preparations. The carers have noticed she needs more prompting with tasks and have advised she doesn't use the hob when they are not there. She doesn't want to go into care.</p>	<p>CFS 7 Living with severe frailty</p> <p>Doris is 93. She lives in a care home, she has dementia and is now non-verbal. She needs help for all activities such as washing, dressing and uses a standing hoist to get from bed to chair. She doesn't have capacity. Whenever she is somewhere different, she becomes agitated. Family live down south and visit a few times per year, many of her friends and close relatives have now passed.</p>	<p>CFS 8 Living with very severe frailty</p> <p>Bob is 90. He has had a respiratory virus which has gone on his chest. His heart failure has made this worse and his recent stroke which has meant he is no longer mobile. He has expressed his wishes and has an advanced care plan in place. He has had a visit from the ACP and the nursing home are giving him nebulizers and monitoring him. He is not thought to be in the last six months of life.</p>	<p>CFS 9 Terminally Ill</p> <p>Alan is 89. He is in the hospice for end of life care, his wife is elderly and can't manage him at home. The hospice is providing all of his care. His wife is present much of the day.</p>
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No Frailty

Mild Frailty

Moderate Frailty

Severe Frailty

Terminally Ill

CFS 1-3 Prehab
Monitor. Advice – diet, nutrition, activity, MSK physio if needed

CFS 3-6 Rehab
Active rehab and management to reverse signs of frailty or prevent further deterioration

CFS 5-8 Enablement
Management of non-reversible features and enabling input to optimise function, participation and QOL

CFS 8-9 Palliative
Palliative care services, advanced care planning, DNAR, carer support



Patient Education

Give yourself the gift of a longer, healthier life.



Join a UK-wide community this September, building simple habits that will boost your health and happiness.

Free and expert led: sign up today!
wels.open.ac.uk/take5



DO YOU WANT TO AGE WELL?

ARE YOU...

- In your golden years?
- Near retirement?
- A senior citizen?

WHAT IS IT?

A kick start to healthy ageing for the whole UK.

HOW DO YOU GET INVOLVED?

30 day challenge from 1st September

Scan the QR code for a quick and easy sign up!

The **Take Five Team** will support and empower you throughout the month with: **emails, encouragement, ideas and cheer leading.**

YOU CONTRIBUTE TO SCIENCE!

We'll ask you to complete surveys to better our understanding of ageing and habit formation. With our ageing population, this will be pivotal in informing policy and care for years to come.

IT'S A WIN WIN!

As well as helping science, this will have a positive impact on your health. You will feel better, physically and mentally.

LONG HAUL BENEFITS!

After a 30 day commitment, maybe you will find it's easy to keep Taking Five and Ageing Well.

HOW DO YOU GET INVOLVED?

You choose your own adventure!

WHY SHOULD YOU TAKE PART?

It's easy and fun: you take up simple actions that will improve your health and well being.

STAY FIT

Ageing is inevitable but there are ways to **age better!**

EAT WELL

However you see yourself, **get a health boost this September.**

HYDRATE

KEEP SOCIAL

STAY ON THE BALL

TAKE FIVE TO AGE WELL



Join this national community!

To find out more, visit:
wels.open.ac.uk/take5

Summary

- Frailty is a long-term condition that has the capability to take away a person's independence and health. Whilst it is common in older people, it is not an inevitability of ageing.
- Early identification of frailty can help support people to get access to the right care at the right time to enable them to live an independent and healthy life. There are a variety of tools used to identify frailty, we are asking you to use the Clinical Frailty Scale (CFS) on all patients 65+
- Once identified, a person with frailty can then be supported through a comprehensive geriatric assessment (CGA) which provides a holistic multidisciplinary review to ensure all potential issues are supported.



References and Useful documents



- British Geriatric Society (BGS) 2018 BGS website
- British Geriatric Society BGS toolkit for comprehensive geriatric assessment in primary care settings
- <https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-08-23/CGA%20in%20Primary%20Care%20Settings.pdf>
- British Geriatric Society 2023 joining the dots; A blueprint for preventing and managing frailty in older people
- <https://www.bgs.org.uk/policy-and-media/joining-the-dots-a-blueprint-for-preventing-and-managing-frailty-in-older-people>
- British Geriatric Society Comprehensive Geriatric Assessment (CGA) <https://www.bgs.org.uk/cgatoolkit>
- NHS RightCare: Frailty Toolkit 2019 NHS England <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf>
- NICE 2016 Multimorbidity clinical assessment and management NG 56 <https://www.nice.org.uk/guidance/ng56>
- Frailty a framework of core capabilities 2018 Skills for Health <https://www.skillsforhealth.org.uk/wp-content/uploads/2021/01/Frailty-framework.pdf>
- NICE 2016 QS136 Transition between inpatient hospital settings and community or care home settings for adults with social care needs <https://www.nice.org.uk/guidance/qs136>
- Healthcare improvement Scotland read codes guide
- <https://ihub.scot/media/6442/20190705-efi-read-codes-guide-v10.pdf>